VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the

Patient's Name (Last, First, Middle Initial) | Mother's Maiden Name (Last, First, Middle Initial)

Address (Street/Road/POBox) | Telephone Number ( )

City | County | State | Zip Code | Email address:

Social Security Number | Date of Birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female | Ethnicity (Check one) ☐ Hispanic ☐ Non-Hispanic

Race (Check one) ☐ African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other | Name of Physician/Clinic

Eligibility Status (Check all that apply) This section must be completed. ☐ **Medicaid Eligible** ☐ **Medicare** ☐ **No Health Insurance** ☐ **Insured, Vaccines Covered** ☐ **Badger Care** ☐ **Native American** ☐ **Insured, Vaccines Not Covered**

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial) | Relationship to Patient

Okay to share immunization data with WI ☐ Yes ☐ No | Is reminder or recall contact allowed? ☐ Yes ☐ No | Would you like reminder/recall sent to you? ☐ Yes ☐ No

-I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s)

-Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

-I give permission to share my child's immunization records including those provided to School(s) with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Check here if you do not ☐

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's be | Date Signed

FOR OFFICE USE

* RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Subcutaneous injections are administered in the muscle "area".

Vaccine	Route	Site Admin*	Dose Number	Manufacturer	Lot Number	Exp Date	CDC Form Date
DTaP	IM	RV LV RD LD	1 2 3 4 5	GSK			05/17/07
DTaP-IPV Combined (Kinrix)	IM	RV LV RD LD	1 2 3 4	GSK			Use dates from DTaP,Polio
DTaP-IPV-Hib Combined (Pentacel)	IM	RV LV RD LD	1 2 3 4	SP			Use dates from DTaP,Hib,Polio
Hepatitis A	IM	RV LV RD LD	1 2	GSK			10/25/11
Hepatitis B	IM	RV LV RD LD	1 2 3	GSK			7/18/07
Hib	IM	RV LV RD LD	1 2 3 4	Merck			12/16/98
HPV (Gardasil) (Human Papillomavirus)	IM	RV LV RD LD	1 2 3	Merck			5/03/11
Influenza	IM	RV LV RD LD	1 2				Use latest VIS
Meningococcal Conjugate (MVC4)	IM	RV LV RD LD	1	SP			10/14/11
MMR	SQ	RV LV RD LD	1 2	Merck			3/13/08
Pneumococcal Conjugate (PCV13) (Prevnar)	IM	RV LV RD LD	1 2 3 4	Wyeth			04/16/10
Polio	IM or SQ	RV LV RD LD	1 2 3 4	SP			11/08/11
Rotavirus	Oral	RV LV RD LD	1 2 3	Merck			12/06/10
Td	IM	RV LV RD LD	1 2 3 4 5	SP			11/18/08
Tdap (Boostrix)	IM	RV LV RD LD	1	GSK			11/18/08
Varicella (Chickenpox)	SQ	RV LV RD LD	1 2	Merck			3/13/08
Other		RV LV RD LD	1 2 3 4				

Signature & Title - Person Administering Vaccine Staff Nurse RN BSN | **Date Vaccine Administered**